UFT
UNITED FEDERATION OF TEACHERS
WELFARE FUND
LOCAL 2, AMERICAN FEDERATION OF TEACHERS, AFL-CIO

UFT WELFARE FUND
Mandatory Generic Price Waiver Form

MEMBER INFORMATION – PLEASE PRINT
Please return completed form to: UFT Welfare Fund, Attn: Pharmacy Dept., 52 Broadway, 7th Floor, New York, NY 10004

EMPLOYEE COMPLETES

MEMBER NAME	BIRTHDATE	SEX	SS # OR WELFARE FUND ID #

HOME ADDRESS CITY STATE ZIP	TELEPHONE # ( )

SCHOOL OR BUREAU	SCHOOL TELEPHONE #	Check Type of Medical Coverage You Have Selected ☐ H.I.P./HMO ☐ G.H.I. Type C ☐ G.H.I.-CBP ☐ Other	Are you covered by another Prescription Benefits plan? ☐ Yes ☐ No If Yes, Specify Below

NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS	POLICY/PLAN NUMBER

PATIENT INFORMATION – Required if claim is for Spouse/Domestic Partner or Child

PATIENT NAME	BIRTHDATE	SOCIAL SECURITY #

RELATIONSHIP TO MEMBER ☐ Spouse ☐ Domestic Partner ☐ Child	Are you covered by another Prescription Benefits plan? ☐ Yes ☐ No If Yes, Specify Below

NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS	POLICY/PLAN NUMBER

SIGNED (MEMBER) _____ DATE _____

TO BE COMPLETED BY PHYSICIAN FOR EVALUATION BY THE FUND'S MEDICAL ADVISOR
(Please enclose any additional medical information you deem pertinent)

PHYSICIAN COMPLETES

PHYSICIAN NAME	TELEPHONE # ( )

ADDRESS CITY	STATE ZIP

PATIENT'S NAME (First, M.I., Last)	DATE FIRST CONSULTED

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY FOR WHICH THE EXCEPTION IS REQUESTED

ANTICIPATED DURATION OF DRUG TREATMENT	BRAND NAME DRUG PRESCRIBED	GENERIC EQUIVALENT REQUESTED

Have you tried a generic equivalent drug to treat this condition for this patient? ☐ Yes ☐ No

If **Yes:** 1. When and for how long? _____

2. Describe this patient's specific adverse reaction caused by use of the generic medication: _____

3. Do you attribute this patient's reaction exclusively to the use of the generic drug? ☐ Yes ☐ No

4. In your opinion, why do you believe the generic drug caused this reaction in this patient? _____

5. In your opinion, could lack of effectiveness of the generic medication be considered extremely serious or life-threatening for this patient?

☐ Yes ☐ No Explain: _____

If **No:** Please explain why you would not prescribe a generic drug for this patient. (Include appropriate documentation) _____

Physician's Signature and Office Stamp _____ DEA # _____ Date _____

REVISED 5/13